DOTTIE'S PHARMACY
specialty & compounding

Dermatology Medications Enrollment Form

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Charleston, SC 29412
PH: (843) 501-9500
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Date: _____ Needs by date: _____ Ship to: Patient ___ Office: ___ Other: _____

Patient Information:
Patient Name: _____
Address: _____
City, State, Zip: _____
Main Phone: _____
Alternate Phone: _____
Last 4 of SSN: _____ Height _____○ in ○cm Weight _____○ lbs ○ kg
Date of Birth: _____ ○ Male ○ Female

Prescriber Information:
Prescriber Name: _____
DEA: _____ NPI: _____
Group: _____
Address: _____
City, State, Zip: _____
Phone: _____ Fax: _____
Contact Person: _____

INSURANCE INFORMATION: PLEASE FAX A COPY OF PRESCRIPTION CARD AND MEDICAL CARD (FRONT AND BACK)

Clinical Information: Statement of Medical Necessity

Primary Diagnosis: _____ Date of Diagnosis/ Years with Disease: _____ Allergies:_____ ○ NKDA

ICD -10 code: ○ L40.0 Psoriasis ○ L40.50 Psoriatic Arthritis ○ L20.9 Atopic Dermatitis ○ L73.2 Hidradenitis Suppurativa ○ Other ICD-10 Code: _____

%BSA affected: _____ Location: ○ Hands ○ Feet ○ Scalp ○ Groin ○ Nails Other: _____

Severity: ○ Moderate ○ Moderate to Severe ○ Severe ○ Symptoms present ≥ 1 year

Prior Failed medications: _____ Reason for discontinuation: _____

Current Medications: _____ Renal Dysfunction: ○ Yes ○ No Current SCr: _____ CrCl: _____ mL/min

Does patient have a latex allergy? ○ Yes ○ No **Has patient received TB/PPD test? ○ Yes ○ No** **PPD Test date: ____/____/____ Result: _____**

Prescription Information

Medication	Dose/ Strength Available	Directions	Quantity	Refills
Cosentyx®	○ 150 mg/mL Pen ○ 150 mg/mL Prefilled Syringe ○ 300 mg/mL (2 x 150 mg) Pen ○ 300 mg/mL (2 x 150 mg) Prefilled Syringe	○ Induction: Inject 150 mg SC **ONCE** weekly at weeks 0, 1, 2, 3, and 4 ○ Maintenance: Inject 150 mg SC every 4 weeks ○ Induction: Inject 300 mg SC **ONCE** weekly at weeks 0, 1, 2, 3, and 4 ○ Maintenance: Inject 300 mg SC every 4 weeks		
Dupixent®	○ 300mg/2mL Prefilled Syringe	○ Induction: Inject 600 mg (given as 2 x 300mg) SC **ONCE** ○ Maintenance: Inject 300 mg once **EVERY OTHER** week		
○ Enbrel® ○ Erelzi ™	○ 25 mg/0.5 mL Prefilled Syringe ○ 25 mg Vials ○ 50 mg/mL Sureclick ○ 50 mg/mL Prefilled Syringe	○ Induction: Inject 50 mg SC **TWICE** a week (72-96 hours apart) for 3 months ○ Maintenance: Inject 50 mg SC **ONCE** weekly ○ Child ≥ 4 y/o Inject 0.8mg/kg = _____mg (max of 50mg) SC **ONCE** weekly		
○ Humira® ○ Amjevita ™ ○ Cyltezo ™	○ Psoriasis Pen Starter Kit ○ Hidradenitis Suppurativa Starter Kit ○ 40 mg/0.8 mL Pen ○ 40 mg/0.8 mL Prefilled Syringe	○ PS Induction: Inject 80 mg (2 x 40 mg) SC **on day 1**, then 40 mg **on day 8**, then 40 mg **EVERY OTHER** week. ○ PS Maintenance : Inject 40 mg SC **EVERY OTHER** week		
○ Humira® Citrate-free	○ 40 mg/0.4 mL Pen ○ 40 mg/0.4 mL Prefilled Syringe	○ HS Induction part 1 for HS: Inject 160 mg (4 x 40 mg) SC **on day 1,** Inject 80 mg (2 x 40 mg) SC **on day 15** ○ HS Maintenance: Inject 40 mg SC **ONCE** weekly **beginning on day 29**		
Otezla®	○ Starter Therapy Pack	○ Induction with Oral Tablets: Day 1: 10 mg in AM; Day 2: 10 mg in AM and 10 mg in PM; Day 3: 10 mg in AM and 20 mg in PM; Day 4: 20 mg in AM and 20 mg in PM; Day 5: 20 mg in AM and 30 mg in PM; Day 6 and thereafter: 30 mg twice daily. ○ Renal dosing CrCl < 30 mL/min Induction: 10 mg in AM on days 1-3; titrate using AM doses only (skip evening doses) to 20 mg on days 4-5. Day 6 and thereafter: 30 mg once daily in AM		
	○ 30 mg Oral Tablets	○ Maintenance: Take 1 tablet by mouth twice daily. (Has starter pack been given? Yes / No) ○ Renal dosing CrCl < 30 mL/min Maintenance: 30 mg once daily in AM		
Skyrizi ™	○ 75 mg/ 0.83 mL Prefilled Syringe	○ Induction: Inject 150 mg (2 x 75 mg) SC **ONCE** at weeks 0 and 4 ○ Maintenance: Inject 150 mg SC every 12 weeks		
Siliq®	○ 210 mg/ 1.5 mL Prefilled Syringe	○ Induction: Inject 210 mg SC at weeks 0, 1, and 2 ○ Maintenance: Inject 210 mg SC once every 2 weeks		
○ Remicade® ○ Inflectra® ○ Renflexis ™	○ 100 mg Vial	○ Induction: Infuse 5 mg/kg =_____ mg IV at weeks 0, 2, and 6 ○ Maintenance: Infuse 5 mg/kg =_____ mg IV every 8 weeks	____# of Vials	
Simponi®	○ 50 mg/ 0.5 mL SmartJect ○ 50 mg/ 0.5 mL Prefilled Syringe	○ Inject 50 mg SC **ONCE A MONTH**		
Stelara®	○ 45 mg/ 0.5 mL Prefilled Syringe (Wt ≤100kg) ○ 90 mg/mL Prefilled Syringe (Wt >100kg)	○ Wt ≤100kg: Inject 45 mg on day 0, then week 4, then every 12 weeks ○ Wt >100kg: Inject 90 mg on day 0, then week 4, then every 12 weeks		
Taltz®	○ 80 mg/ mL Autoinjector ○ 80 mg/ mL Prefilled Syringe	○ Induction: Inject 160 mg SC **ONCE**, then 80 mg at week 2,4,6,8,10, and 12 ○ Maintenance: Inject 80 mg SC every 4 weeks		
Tremfya ™	○ 100mg/ml Prefilled Syringe	○ Induction: Inject 100 mg SC at weeks 0 and 4 ○ Maintenance: Inject 100 mg SC every 8 weeks		
Cimzia ®	○ 200 mg/mL Vial ○ 200 mg/mL Prefilled Syringe ○ Starter Kit 6 x 200 mg/mL	○ Induction: Inject 400 mg (2 x 200 mg) SC **ONCE** at weeks 0, 2, and 4 ○ Maintenance: Inject 200 mg once **EVERY OTHER** week ○ Maintenance: Inject 400 mg (2 x 200 mg) once every 4 weeks		
Orencia ®	○ 125 mg/mL ClickJect ○ 50 mg/ 0.4 mL Prefilled Syringe ○ 87.5 mg/ 0.7 mL Prefilled Syringe ○ 125 mg/mL Prefilled Syringe ○ 250 mg Vial	○ IV Induction: Infuse weight based dose: _____ mg IV every 0, 2, 4 weeks [< 60 kg = 500 mg; 60-100 kg = 750 mg; > 100 kg = 1000 mg] ○ IV Maintenance: Infuse weight based dose: _____ mg IV every 4 weeks [< 60 kg = 500 mg; 60-100 kg = 750 mg; > 100 kg = 1000 mg] ○ SC Maintenance: Inject 125 mg SC once weekly (may initiate SC with or without IV induction) - With IV induction start SC injection within 24 hrs of the IV infusion		
Eucrisa ™	○ 2% Ointment – 60 g tube	Apply a thin layer to affected area(s) **TWICE DAILY**		
Other: _____				

Prescriber Signature: _____ _____ Date: _____

Dispense as Written Product Substitution Permitted